

Health Net Employer Group Enrollment Form



Main subscriber ID:

Effective date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please contact Health Net Seniority Plus Employer (HMO) if you need information in another language or format.

To enroll in Health Net, please provide the following information

Employer or union name:

Group #:

Last name:

First name:

Middle initial: Mr. Mrs. Ms.

Birth date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Sex:

M F

Home phone number:

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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Beneficiary mobile phone number:

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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Permanent resident street address (don't enter a PO Box. For individuals experiencing homelessness, a PO Box may be considered your permanent residence address):

Experiencing Homelessness

City:

County:

State:

ZIP code:

Mailing address (only if different from your permanent residence address)

Street address:

City:

State:

ZIP code:

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card)

Medicare number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Is entitled to:

HOSPITAL (Part A)

MEDICAL (Part B)

Effective date

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Please read and answer these important questions

1. Are you the retiree? Yes No

If "Yes," retirement date:

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If "No," name of retiree:

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2. Are you covering a spouse or dependents under this employer or union plan? Yes No

If "Yes," name of spouse:

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Name of dependents:

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3. Do you or your spouse work? Yes No

4. Some individuals may have other drug coverage, including other private insurance, workers' compensation, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Health Net?

Yes No

If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:

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ID # for this coverage:

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5. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If "Yes," please provide the following information:

Name of institution:

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Phone number of institution:

	-		-	
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Address of institution (number and street):

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Please choose a Primary Care Physician (PCP):

PCP access number:

Is this your current PCP? Yes No

Please choose a Primary Care Physician Group (PPG):

Is this your current PPG? Yes No

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- No, not of Hispanic, Latino/a or Spanish Origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino/a or Spanish Origin
- I choose not to answer

What's your race? Select all that apply.

- American Indian or Alaska Native
- Black or African American
- Asian:
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian and Pacific Islander:
- Guamanian or Chamorro
- Native Hawaiian
- Samoan
- Other Pacific Islander
- White
- I choose not to answer

What is your gender identity? Select one.

- Woman
- Man
- Non-Binary
- I use a different term:
- I choose not to answer

Which of the following best represents how you think of yourself? Select one.

- Lesbian or gay
- Straight, that is, not gay or lesbian
- Bisexual
- I use a different term:
- I don't know
- I choose not to answer

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

Spanish Chinese Large print Audio CD Data CD Braille

Please contact Health Net at 1-800-275-4737 if you need information in an accessible format or language other than what is listed above. From October 1 through March 31, our office hours are 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, our office hours are Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends and on federal holidays. TTY users should call 711.

Please read and sign below

By completing this enrollment application, I agree to the following:

Health Net Seniority Plus Employer (HMO) is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15–December 7) or under certain special circumstances.

Health Net serves a specific service area. If I move out of the area that Health Net serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Health Net when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I understand that beginning on the date Health Net Seniority Plus Employer (HMO) coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net and other services contained in my Health Net *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

Please read and sign below (cont.)

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Health Net, he/she may be paid based on my enrollment in Health Net.

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request from Medicare.

Signature:

Today's date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone number:

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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Relationship to enrollee:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:

Relationship to enrollee:

Signature:

National Producer Number (Agents/Brokers only):

Please read and sign below

BINDING ARBITRATION: All benefits offered under this Medicare health plan, including optional supplemental benefits, if any, are subject to the Medicare appeals procedures and are not subject to arbitration. Conversely, all other claims including, but not limited to, the following claims, regardless of how they are characterized, are subject to arbitration: Determinations on items or services purchased by my employer, over and above the Medicare approved benefit package, such as payments of premiums or beneficiary cost-sharing provided by my employer, any disputes between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan that is not subject to the Medicare appeals process, including any claim for medical or hospital malpractice (a claim that medical services were unauthorized or were improperly, negligently or incompetently rendered), for premises liability, or relating to the delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under State law and not by lawsuit or resort to court process. By signing below, I agree to give up our right to a jury trial and accept the use of binding arbitration for claims that are not subject to the Medicare appeals procedures. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature:

Today's date:

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Health Net has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

ATTENTION: If you need help in your language, call 1-800-275-4737 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-275-4737 (TTY: 711). These services are free.

انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على 1-800-275-4737 (TTY: 711). تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على 1-800-275-4737 (TTY: 711). هذه الخدمات مجانية.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ցանկանում եք օգնություն ստանալ ձեր լեզվով, զանգահարեք 1-800-275-4737 (TTY՝ 711): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, օրինակ՝ բրայլյան գրատեսակով և խոշոր տառաչափով փաստաթղթեր: Չանգահարեք 1-800-275-4737 (TTY՝ 711): Այս ծառայություններն անվճար են:

注意：如果您需要以您的语言提供的帮助，请致电1-800-275-4737（TTY：711）。此外，还为残疾人提供辅助和相关服务，如盲文文件和大字体文件。请致电1-800-275-4737（TTY：711）。这些服务均免费提供。

注意：如果您需要以您母語提供的協助，請致電1-800-275-4737 (TTY：711)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電1-800-275-4737 (TTY：711)。這些服務均為免費。

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-800-275-4737 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਵਰਗੀਆਂ ਅਸਮਰੱਥਾ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਉਪਲਬਧ ਹਨ। 1-800-275-4737 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਮੁਫਤ ਸੇਵਾਵਾਂ ਹਨ।

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो 1-800-275-4737 (TTY: 711) पर कॉल करें. विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं. 1-800-275-4737 (TTY: 711) पर कॉल करें. ये सेवाएं निःशुल्क हैं.

THOV MUAB SIAB RAU: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-800-275-4737 (TTY: 711). Tsis tas i ntawd, peb tseem muaj cov neeg pab thiab cov kev pab cuam rau cov neeg uas muaj cov kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv su rau neeg dig muag thiab ntawv luam loj. Hu rau 1-800-275-4737 (TTY: 711). Cov kev pab cuam no pab dawb xwb.

注意：言語のヘルプが必要な場合は1-800-275-4737（TTY：711）までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。1-800-275-4737（TTY：711）にお電話ください。これらのサービスは無料です。

주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 1-800-275-4737(TTY: 711)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. 1-800-275-4737(TTY: 711)번으로 연락해 주십시오. 이러한 서비스는 무료입니다.

ຂໍຄວນເອົາໃຈໃສ່: ຫາກທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-800-275-4737 (TTY: 711). ນອກຈາກນີ້ ຍັງມີຄວາມຊ່ວຍເຫຼືອສໍາລັບຜູ້ພິການ ເຊັ່ນ: ເອກະສານເປັນອັກສອນນູນ ແລະ ຕົວພິມໃຫຍ່ອີກດ້ວຍ. ໃຫ້ໂທຫາ 1-800-275-4737 (TTY: 711). ບໍລິການເຫຼົ່ານີ້ຟຣີ.

LIOUH EIX: Oix se nongc zuqc meih nyei wac jouh mienh bong zouc, cingv mboqv 1-800-275-4737 (TTY: 711). Hac haih weic waic fangx mienh zoux sic taengx qaqv, hnavg mangh wenh souh nzangc caux domh nzangc yenx benx nyei souh nzangc. Mboqv 1-800-275-4737 (TTY: 711). Naiv deix bong taengx meih se mv siou zinh.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-800-275-4737 (TTY: 711) ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្នាបសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-800-275-4737 (TTY: 711)។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។

توجه: اگر به زبان خودتان نیاز به کمک دارید با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید. پشتیبانی و خدمات برای افراد دارای معلولیت، مانند اسناد با خط بریل و چاپ درشت، نیز موجود است. با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید. این خدمات رایگان است.

ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру 1-800-275-4737 (TTY: 711). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру 1-800-275-4737 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma llame al 1-800-275-4737 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al 1-800-275-4737 (TTY: 711). Estos servicios son gratuitos.

ATENSYON: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-800-275-4737 (TTY: 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-275-4737 (TTY: 711). Libre ang mga serbisyonang ito.

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทร 1-800-275-4737 (TTY: 711) นอกจากนี้ ยังมีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารที่เป็นอักษรเบรลล์และเอกสารที่ใช้ตัวอักษรขนาดใหญ่ โปรดโทร 1-800-275-4737 (TTY: 711) บริการเหล่านี้ไม่มีค่าใช้จ่าย

УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером 1-800-275-4737 (TTY: 711). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером 1-800-275-4737 (TTY: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số 1-800-275-4737 (TTY: 711). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và bản in cỡ chữ lớn cũng được cung cấp. Gọi số 1-800-275-4737 (TTY: 711). Các dịch vụ này miễn phí.

